STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 00 B. WING	06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaints IN00108839 and IN00109051. Complaints IN00108839 and IN00109051 substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226, and F322. Survey dates: June 4, 6, 7, 2012 Facility number 000149 Provider number 155245 AIM number 100266840 Survey team: Chuck Stevenson RN Census bed type: SNF/NF: 61 Total: 61 Census payor type: Medicare: 11 Medicaid: 41 Other: 9 Total: 61 Sample: 11 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed 6/11/12 Cathy Emswiller RN			

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to ensure unusual	F0225	What corrective action(s) will be accomplished for those residents found to have been affected by	07/07/2012

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	occurrences were reported to the State Agency and thoroughly investigated as required by law for 3 residents (Resident D, injury of unknown origin requiring hospital treatment), (Resident K, G-tube condition requiring hospital treatment), (Resident L, allegation that men in his room threatened to kill him.) 3 of 3 residents reviewed for reporting of unusual occurrences in a sample of 11. Findings include: 1. The record of Resident D was reviewed on 6/06/12 at 1:15 p.m. Diagnoses included, but were not limited to, cerebrovascular disease, vascular dementia, epilepsy, atrial fibrillation, and hypertension. A significant change Minimum Data Set (M.D.S.) assessment dated 4/10/12 indicated Resident D was cognitively impaired, did not ambulate, required staff assistance with activities of daily living, and was incontinent of bowel and bladder. Nurse's notes indicated: 4/09/12 12:00 p.m. "...Res (resident) found on floor bed alarm going off. Laying on (symbol for "left") side of body by bedside. 4 x 3 cm (centimeter) 0.8 cm		the deficient practice: It is this facility's policy to ensure all unusual occurrence are reported to the State Agency and thoroughly investigated. Resident (D) injury is healed and sutures removed. The Administrator, D.O.N., Department Heads, charge nurses and all staff have been re-educated as to follow the facility's Reporting Criteria as that all resident involved in a incident or accident requiring sutures must be reported to the proper state agencies. Resident (K) g-tube site has been treated for the diagnosis of cellulitis. Resident (L) resident was comforted at the time and has no further delusions of two white/one black men in room trying to kill him while he was walking on water with Jesus. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by this practice. From this point on all reports or occurances of unusual occurrences will be reported to the State Agency and thoroughly investigated as required by law. The Administrator will ensure every staff member is educated on the reporting of unusual occurrence and what qualifies as an unusual occurrence. What measures will be put into place or what systemic changes will be made to ensure that the deficient	

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	deep skin tear noted on (symbol for "left") eyebrow bleeding. Pressure drsg (dressing) applied stopped bleeding...MD notified N/O (new order) received..." 4/09/12 12:30 p.m. "Res left facility on stretcher to (acute care hospital)." 4/09/12 6:10 p.m. "Patient returned from hospital on stretcher...(symbol for "left") eyebrow has 4 sutures..." A Nurse Practitioner's Visit Note dated 4/12/12 indicated "Pt (patient) fell out of bed 4/9 and hit his head on the floor. Pt found on the floor w (with) (symbol for "left") eye laceration..." During an interview with the Director of Nursing on 6/06/12 at 2:30 p.m. she indicated this incident had not been reported to the State Agency, and that there was no formal investigation into the circumstances of Resident D's injury. 2. The record of Resident K was reviewed on 6/05/12 at 9:15 a.m. Diagnoses included, but were not limited to, a history of closed head injury, severe mental retardation, seizure disorder, aphasia, dysphagia, and gastro-esophageal reflux disease.		practice does not recur; An in-service held June 26, 2012 reviewed the reporting criteria for identifying and unusual occurrence and reporting an unusual occurrence. The DON or designee will monitor (10) charts weekly to review all nurse's notes which might include an unusual event. These monitoring will continue until (4) consecutive weeks of 100% compliance are achieved. All staff who fail to report an unusual occurrence will be progressively disciplined. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: At the monthly Quality Assurance Meeting held monthly the results of the unusual occurrences will be reviewed. Any negative findings with a pattern the Administrator will assign a review team to follow until positive results are achieved.	

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	A quarterly Minimum Data Set (M.D.S.) assessment dated 5/02/12 indicated Resident K had significant cognitive deficits, required total staff assistance for all activities of daily living, was incontinent of bowel and bladder, and received all nutrition through his gastrostomy tube. A nurse's note dated 5/23/12 at 2:30 p.m. indicated "pt (patient) has an open area under GT site. Area around site looks swollen (symbol for "and") irritated. Called (treating physician) to inform rec. (received) order to send to ER for evaluation (symbol for "and") tx (treatment). Pt did agree that pt did want to go to the hospital..." An Emergency Department Triage Report dated 5/23/2012 at 3:38 p.m. indicated: "Chief Complaint: G-tube infection. Data: Pt (patient) presents from ECF (Extended Care Facility) with infection to G-tube. G-tube is purulent with foul smelling discharge..." A physician's dictated "Emergency Room Report" dated 5/23/12 indicated: "History of present illness:..The patient is a (age documented) year old male,			

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	chronically handicapped...presents to the Emergency Department for possible G-tube infection...there is some purulent drainage... Abdomen: Soft. He has a G-tube in place. There has been what appears to be essentially no care of the G-tube. There is significant granulation tissue with hypertrophic (enlarged or overgrown) skin. There is some drainage which is probably gastric contents. There is an erythematous (reddened; a sign of inflammation or infection) patch primarily around the G-tube site and progressing to the lateral (to the side) aspect... The patient does need G-tube care. It is felt at this point that he is not getting this at the facility. I have involved nursing supervisor, forensic nurse to take pictures of the wound and somehow to arrange G-tube care for this gentleman. We were able to cleanse the G-tube site. There was significant invasion of the soft tissue with the G-tube cuff. This was removed from the soft tissue. Photographs were obtained..." A hospital document titled "Flow Sheet" dated 5/23/12 indicated at these times: 5:00 p.m. "...entered room to assess			

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	pt...G-tube site oozing brownish purulent drainage around site, reddened around site/swollen also..." 7:25 p.m. "...assumed care of pt. G-tube insertion site red with puss like drainage noted site has strong odor swelling noted pt. has dried crusted drainage that is dark red in color around site cleaned site with tech holding pts arm, pt appeared to be in extreme pain when site touched..." 7:35 p.m. (Forensic Nurse) at bedside taking pictures of G-tube. The plastic disk at insertion site sitting at a 90 degree angle straight up it appears that half of disk is embedded into pts (patient's) skin the top of disk rubs the pts abd (abdomen) when pt is sitting up which has caused a sore...doctor at bedside the disk pulled out of skin and area that is open where disk was embedded cleaned with saline and dressed with 4 x 4's (dressings) that are y-ed and layered around tube to keep disk from embedding again." During a meeting on 6/05/12 at 12:35 with the Director of Nursing (D.O.N.) and the Assistant Director of Nursing (A.D.O.N.), the D.O.N. indicated this incident had not been reported to the State Agency as an unusual occurrence, and that no formal investigation of the incident had been completed.			

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	3. The record of Resident L was reviewed on 6/06/12 at 9:45 a.m. Diagnoses included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease. hypertension, and chronic pain. A quarterly Minimum Data Set (M.D.S.) assessment dated 5/16/12 indicated Resident L was moderately cognitively impaired, required assistance with activities of living, and was incontinent of bowel and bladder. A nurse's note dated 4/14/12 at 7:00 p.m. indicated "Res (resident) alert this shift...stated to this nurse 'There was two white men/one black man in his room saying they was going to kill him.' Also stated he was walking on water with Jesus. Asked this nurse if did I believe him, this nurse informed Res there was (symbol for "no") men in his room wanting to kill him...Res. stated 'I'm not lying.' There were no nurse's notes indicating that this incident was reported to any supervisory or management personnel, and no indication any investigation was done, or any interventions put in place to reassure Resident L that he was safe from			

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	harm. During a meeting with the D.O.N. and A.D.O.N. on 6/06/12 at 3:45, both indicated they were unaware of the incident of 4/14/12 where Resident L indicated men had threatened to kill him. The D.O.N. also indicated she was confident the Administrator was unaware of this incident, and that it had not been reported to the State Agency, and that no investigation had been done. 3.1-28(c)(2) 3.1-28(d)(2)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure unusual occurrences were reported to the State Agency and thoroughly investigated as required by law and facility policy for 3 residents (Resident D, injury of unknown origin requiring hospital treatment), (Resident K, G-tube condition requiring hospital treatment), (Resident L, allegation that men in his room threatened to kill him.) 3 of 3 residents reviewed for reporting of unusual occurrences in a sample of 11. Findings include: 1. The record of Resident D was reviewed on 6/06/12 at 1:15 p.m. Diagnoses included, but were not limited to, cerebrovascular disease, vascular dementia, epilepsy, atrial fibrillation, and hypertension. A significant change Minimum Data Set (M.D.S.) assessment dated 4/10/12 indicated Resident D was cognitively	F0226	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is this facility's policy to ensure all unusual occurrence are reported to the State Agency and thoroughly investigated. Resident (D) injury is healed and sutures removed. The Administrator, D.O.N., Department Heads, charge nurses and all staff have been re-educated as to follow the facility's Reporting Criteria as that all resident involved in a incident or accident requiring sutures must be reported to the proper state agencies. Resident (K) g-tube site has been treated for the diganosis of cellulitis. Resident (L) resident was comforted at the time and has no further delusions of two white/one black men in room trying to kill him while he was walking on water with Jesus. How other residents having the potential to be affectd by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by this practice. From this point on all reports or occurances of unusual	07/07/2012

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	impaired, did not ambulate, required staff assistance with activities of daily living, and was incontinent of bowel and bladder. Nurse's notes indicated: 4/09/12 12:00 p.m. "...Res (resident) found on floor bed alarm going off. Laying on (symbol for "left") side of body by bedside. 4 x 3 cm (centimeter) 0.8 cm deep skin tear noted on (symbol for "left") eyebrow bleeding. Pressure drsg (dressing) applied stopped bleeding...MD notified N/O (new order) received..." 4/09/12 12:30 p.m. "Res left facility on stretcher to (acute care hospital)." 4/09/12 6:10 p.m. "Patient returned from hospital on stretcher...(symbol for "left") eyebrow has 4 sutures..." A Nurse Practitioner's Visit Note dated 4/12/12 indicated "Pt (patient) fell out of bed 4/9 and hit his head on the floor. Pt found on the floor w (with) (symbol for "left") eye laceration..." During an interview with the Director of Nursing on 6/06/12 at 2:30 p.m. she indicated this incident had not been reported to the State Agency, and that there was no formal investigation into the circumstances of Resident D's injury.		occurrences will be reported to the State Agency and thoroughly investigated as required by law. The Administrator will ensure every staff member is educated on the reporting of unusual occurrence and what qualifies as an unusual occurrence What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; An in-service held June 26, 2012 reviewed the reporting criteria for identifying and unusual occurrence and reporting an unusual occurrence. The DON or designee will monitor (10) charts weekly to review all nurse's notes which might include an unusual event. These montioring will continue until (4) consecutive weeks of 100% compliance are achived. All staff who fail to report an unusual occurrence will be progressively disciplined. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assureance program will be put into place: At the monthly Quality Assurance Meeting held monthly the results of the unusual occrrences will be reviewed. Any negative findings with a pattern the Administrator will assign a review team to follow until positive results are achieved.	

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	2. The record of Resident K was reviewed on 6/05/12 at 9:15 a.m. Diagnoses included, but were not limited to, a history of closed head injury, severe mental retardation, seizure disorder, aphasia, dysphagia, and gastro-esophageal reflux disease. A quarterly Minimum Data Set (M.D.S.) assessment dated 5/02/12 indicated Resident K had significant cognitive deficits, required total staff assistance for all activities of daily living, was incontinent of bowel and bladder, and received all nutrition through his gastrostomy tube. A nurse's note dated 5/23/12 at 2:30 p.m. indicated "pt (patient) has an open area under GT site. Area around site looks swollen (symbol for "and") irritated. Called (treating physician) to inform rec. (received) order to send to ER for evaluation (symbol for "and") tx (treatment). Pt did agree that pt did want to go to the hospital..." An Emergency Department Triage Report dated 5/23/2012 at 3:38 p.m. indicated: "Chief Complaint: G-tube infection.			

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	Data: Pt (patient) presents from ECF (Extended Care Facility) with infection to G-tube. G-tube is purulent with foul smelling discharge..." A physician's dictated "Emergency Room Report" dated 5/23/12 indicated: "History of present illness:..The patient is a (age documented) year old male, chronically handicapped...presents to the Emergency Department for possible G-tube infection...there is some purulent drainage... Abdomen: Soft. He has a G-tube in place. There has been what appears to be essentially no care of the G-tube. There is significant granulation tissue with hypertrophic (enlarged or overgrown) skin. There is some drainage which is probably gastric contents. There is an erythematous (reddened; a sign of inflammation or infection) patch primarily around the G-tube site and progressing to the lateral (to the side) aspect... The patient does need G-tube care. It is felt at this point that he is not getting this at the facility. I have involved nursing supervisor, forensic nurse to take pictures of the wound and somehow to arrange G-tube care for this gentleman. We were			

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	able to cleanse the G-tube site. There was significant invasion of the soft tissue with the G-tube cuff. This was removed from the soft tissue. Photographs were obtained..." A hospital document titled "Flow Sheet" dated 5/23/12 indicated at these times: 5:00 p.m. "...entered room to assess pt...G-tube site oozing brownish purulent drainage around site, reddened around site/swollen also..." 7:25 p.m. "...assumed care of pt. G-tube insertion site red with puss like drainage noted site has strong odor swelling noted pt. has dried crusted drainage that is dark red in color around site cleaned site with tech holding pts arm, pt appeared to be in extreme pain when site touched..." 7:35 p.m. (Forensic Nurse) at bedside taking pictures of G-tube. The plastic disk at insertion site sitting at a 90 degree angle straight up it appears that half of disk is embedded into pts (patient's) skin the top of disk rubs the pts abd (abdomen) when pt is sitting up which has caused a sore...doctor at bedside the disk pulled out of skin and area that is open where disk was embedded cleaned with saline and dressed with 4 x 4's (dressings) that are y-ed and layered around tube to keep disk			

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	from embedding again." During a meeting on 6/05/12 at 12:35 with the Director of Nursing (D.O.N.) and the Assistant Director of Nursing (A.D.O.N.), the D.O.N. indicated this incident had not been reported to the State Agency as an unusual occurrence, and that no formal investigation of the incident had been completed. 3. The record of Resident L was reviewed on 6/06/12 at 9:45 a.m. Diagnoses included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease. hypertension, and chronic pain. A quarterly Minimum Data Set (M.D.S.) assessment dated 5/16/12 indicated Resident L was moderately cognitively impaired, required assistance with activities of living, and was incontinent of bowel and bladder. A nurse's note dated 4/14/12 at 7:00 p.m. indicated "Res (resident) alert this shift...stated to this nurse 'There was two white men/one black man in his room saying they was going to kill him.' Also stated he was walking on water with Jesus. Asked this nurse if did I believe him, this nurse informed Res there was			

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	(symbol for "no") men in his room wanting to kill him...Res. stated 'I'm not lying.' There were no nurse's notes indicating that this incident was reported to any supervisory or management personnel, and no indication any investigation was done, or any interventions put in place to reassure Resident L that he was safe from harm. During a meeting with the D.O.N. and A.D.O.N. on 6/06/12 at 3:45, both indicated they were unaware of the incident of 4/14/12 where Resident L indicated men had threatened to kill him. The D.O.N. also indicated she was confident the Administrator was unaware of this incident, and that it had not been reported to the State Agency, and that no investigation had been done. 4. An undated facility document titled "Reportable Unusual Occurrences" Received from the D.O.N. on 6/07/12 at 9:00 a.m. and indicated to be a current facility policy indicated; "Purpose: To define reportable, unusual occurrences at the facility to insure compliance with state and federal laws. Policy: Facility intends to be in			

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	compliance with the laws governing reportable unusual occurrences through adherence of the policy of the ISDH. Procedure: Facility will report unusual occurrences within 24 hours to the Long Term Care Division of the ISDH of alleged violations involving mistreatment, neglect or abuse of residents, including injuries of unknown source and misappropriation of property." An undated facility document titled "Investigative Protocol" received from the D.O.N. on 6/07/12 and indicated to be a current facility policy indicated: "Policy: It is the policy of this facility to see that all unusual occurrences are investigated thoroughly and timely so that all necessary action as required by facility policy, regulation or "law" can be taken. This will enable the facility to do all necessary reporting with required time frames." 3.1-28(c)(2) 3.1-28(d)(2)			

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F0322 SS=G	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on record review and interview, the facility failed to ensure a resident with a gastrostomy feeding tube was assessed to accurately reflect the resident's status and condition and to ensure the resident received appropriate care and services to prevent injury to the gastrostomy tube insertion site, resulting in the resident (Resident K) being sent to a hospital emergency room for treatment with a resultant diagnosis of cellulitis, poor wound care, and infection of the gastrostomy tube requiring treatment and antibiotic therapy. 1 resident of 4 reviewed for gastrostomy tube care in a sample of 11. Findings include: 1. The record of Resident K was reviewed on 6/05/12 at 95 a.m. Diagnoses included, but were not limited to, a history of closed head injury, severe	F0322	Castleton Health Care Center respectively request an IDR be scheduled for F322 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident (K) cellulitis (Atbx) treatment has been completed and is healed at this time. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents with g-tubes have the potential to be affected by this practice. The facility currently has a total of four resident with G-Tubes all of the residents with g-tube sites are clean/dry intact and free from any infections. The facility continues to monitor every resident with a g-tube. The G-Tube site is monitored to maintain the status of keeping clean dry and intact and free from infections. The facility has implemented a q shift g-tube site review to ensure proper g-tube care is being	07/07/2012

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	mental retardation, seizure disorder, aphasia, dysphagia, and gastro-esophageal reflux disease. A quarterly Minimum Data Set (M.D.S.) assessment dated 5/02/12 indicated Resident K had significant cognitive deficits, required total staff assistance for all activities of daily living, was incontinent of bowel and bladder, and received all nutrition through his gastrostomy tube. Records indicate Resident K has had a gastrostomy feeding tube since his admission to the facility in January of 1990. A nurse's note for 5/16/12 at 2:45 p.m. indicated: "C.N.A. in resident's room...noted dislodged g/t (gastrostomy tube)...attempted to reinsert x 2 (times 2)...unable to replace g/t..." A nurse's note dated 5/16/12 at 3:30 p.m. indicated "(name of treating physician) called...may send out to (acute care hospital emergency room)...replace g/t." A hospital physician's dictated "Emergency Room Report" dated 5/23/12 included, referring to the emergency room visit of 5/16/12, "He (Resident K) was seen here a week ago, had the G-tube		completed. The DON or designee will monitor all g-tube documentation twice weekly to ensure all monitoring and charting are being completed. This monitoring will be continue until (4) weeks of 100% compliance is achieved. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: At an in-service held June 26th, 2012 the aspect of maintaining a g-tube and keeping it clean dry and intact and free from infection was discussed. All Nurses at Castleton have been given a refresher course on G-Tube care. The monitoring tool was also educated and implemented to all nurses. Any nurse who fails to follow proper procedures will be progressively disciplined up to and including termination. How the corrective actions(s) will be monitored to ensue the deficient practice will not recur, i.e., what quality assurance program will be put into place; At the monthly Quality Assurance Monthly Meeting the review of all monitoring of g-tube care will be discussed. Any negative patterns occur the Administrator will appoint a quality review team to follow until 100% compliance in met and retained.	

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	replaced and at that point, it was felt that there was essentially no G-tube care ongoing..." A nurse's note dated 5/23/12 at 2:30 p.m. indicated "pt (patient) has an open area under GT site. Area around site looks swollen (symbol for "and") irritated. Called (treating physician) to inform rec. (received) order to send to ER for evaluation (symbol for "and") tx (treatment). Pt did agree that pt did want to go to the hospital..." An Emergency Department Triage Report dated 5/23/2012 at 3:38 p.m. indicated: "Chief Complaint: G-tube infection. Data: Pt (patient) presents from ECF (Extended Care Facility) with infection to G-tube. G-tube is purulent with foul smelling discharge..." A physician's dictated "Emergency Room Report" dated 5/23/12 indicated: "History of present illness:..The patient is a 39 year old male, chronically handicapped...presents to the Emergency Department for possible G-tube infection...there is some purulent drainage...			

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	Abdomen: Soft. He has a G-tube in place. There has been what appears to be essentially no care of the G-tube. There is significant granulation tissue with hypertrophic (enlarged or overgrown) skin. There is some drainage which is probably gastric contents. There is an erythematous (reddened; a sign of inflammation or infection) patch primarily around the G-tube site and progressing to the lateral (to the side) aspect... The patient does need G-tube care. It is felt at this point that he is not getting this at the facility. I have involved nursing supervisor, forensic nurse to take pictures of the wound and somehow to arrange G-tube care for this gentleman. We were able to cleanse the G-tube site. There was significant invasion of the soft tissue with the G-tube cuff. This was removed from the soft tissue. Photographs were obtained..." A hospital document titled "Flow Sheet" dated 5/23/12 indicated at these times: 5:00 p.m. "...entered room to assess pt...G-tube site oozing brownish purulent drainage around site, reddened around site/swollen also..." 7:25 p.m. "...assumed care of pt. G-tube			

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	insertion site red with puss like drainage noted site has strong odor swelling noted pt. has dried crusted drainage that is dark red in color around site cleaned site with tech holding pts arm, pt appeared to be in extreme pain when site touched..." 7:35 p.m. (Forensic Nurse) at bedside taking pictures of G-tube. The plastic disk at insertion site sitting at a 90 degree angle straight up it appears that half of disk is embedded into pts (patient's) skin the top of disk rubs the pts abd (abdomen) when pt is sitting up which has caused a sore...doctor at bedside the disk pulled out of skin and area that is open where disk was embedded cleaned with saline and dressed with 4 x 4's (dressings) that are y-ed and layered around tube to keep disk from embedding again." 7:57 p.m. "APS (Adult Protective Services) to be filed on phone for PT (patient)." 8:02 p.m. "(Name of facility) called...report given to (name of facility R.N.) R.N. aware that aps will be contacted about G-tube." 2. An undated facility policy titled "G-Tube Site Care" received from the Director of Nursing On 6/06/12 at 2:40 p.m. and indicated to be a current facility			

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	policy indicated: "Purpose: To keep G-tube site clean and free of infection Policy: G-tube care should be done daily unless complications or infection exist. It should then be done as per physician's order. Procedure: 5. You should assess the G-tube site daily for signs of infection and report: a. Redness b. Drainage, or c. Temperature 8. Document any pertinent observations in the medical record." During a meeting on 6/05/12 at 12:35 with the Director of Nursing (D.O.N.) and the Assistant Director of Nursing (A.D.O.N.), Resident K's record was reviewed, including the following nurse's notes: 5/19/12 6:30 a.m. "...(symbol for "no") s/s (signs or symptoms) of infection at the site..." 5/20/12 11:15 a.m. "...Site (symbol for "without") s/s of infection..." 5/21/12 10:30 p.m. "...Site (symbol for			

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	"without") redness or drainage..." 5/22/12 7:45 a.m. "...(symbol for "no") s/s of infection..." 5/23/12 6:00 a.m. "...(symbol for "no") sign of infection..." The Assistant Director of Nursing indicated she had written the nurse's note of 5/23/12 at 2:30 documenting the condition of Resident K's G-tube site and sending him to the Emergency Room for treatment. The A.D.O.N. also indicated she had interviewed the nurses who had done Resident K's G-tube care on the evening of 5/22/12 and the morning of 5/23/12 and both indicated they had not noted any concerns with the G-tube site. The hospital Forensic Nurse's photographs of Resident K's G-tube site obtained at the Emergency Room and documenting the condition of his G-tube site on admission were reviewed. Both the D.O.N. and the A.D.O.N. indicated they could offer no explanation as to the apparent conflict between the facility's documentation of Resident K's G-tube site condition and that documented in hospital records and photographs, or how this condition could have developed in the time between the nurse's note of 5/23/12 at 6:00 a.m. and his discharge to the hospital for treatment at 2:30 p.m.			

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	3.1-44(a)(2)			